VICTIM COMPENSATION BOARD
BC-VOC-0101 (REV. 3/01)

FOR BOARD USE ONLY

**MENTAL HEALTH BILLING/VERIFICATION (B/V) FORM**

| VOC CLAIM NUMBER | **THIS FORM MUST BE COMPLETED FULLY AND SHOULD BE SUBMITTED WITHIN 30 DAYS OF THE DATE OF TREATMENT** | |
|---|---|---|
| | | |

**SUBMISSION OF THIS BILL DOES NOT ENSURE IT WILL BE PAID. PAYMENT OR PARTIAL PAYMENT OF THIS BILL DOES NOT GUARANTEE THAT OTHER BILLS WILL BE PAID.**

| NAME OF PROVIDER ORGANIZATION OR FACILITY (IF APPLICABLE) | ☐ FOR PROFIT | ☐ NONPROFIT |
|---|---|---|
| | | |

| NAME OF TREATING THERAPIST | LICENSE/REGISTRATION NO. (include prefix) | EFFECTIVE/EXPIRATION DATE |
|---|---|---|
| | | |

TREATING THERAPIST'S LICENSE TYPE: ☐ MFT ☐ MFT INTERN ☐ LCSW ☐ ASSOCIATE MSW

☐ PSYCHIATRIST ☐ PSYCH. ASSISTANT ☐ LICENSED CLINICAL PSYCHOLOGIST ☐ OTHER (PLEASE SPECIFY) _____

| NAME AND TITLE OF SUPERVISING THERAPIST (FOR INTERNS) | SUPERVISOR'S LICENSE NUMBER (include prefix) | EFFECTIVE/EXPIRATION DATE OF SUPERVISING THERAPIST'S LICENSE |
|---|---|---|
| | | |

IF AUTHORIZED, PAYMENT SHOULD BE ISSUED TO: ☐ ORGANIZATION ☐ TREATING THERAPIST ☐ SUPERVISING THERAPIST

PAYEE'S TAX IDENTIFICATION NO.: SSN [ ] _____ OR EIN [ ] _____

| MAILING ADDRESS OF PAYEE (Including city, state, and zip code) | IS THIS A NEW ADDRESS? ☐ YES ☐ NO | TELEPHONE (Include area code) |
|---|---|---|
| | | |

| DATES OF SERVICE | DESCRIPTION OF SERVICE: INDIVIDUAL | GROUP | FAMILY | (SPECIFY OTHER) | PROCEDURE CODE | SESSION LENGTH | BILLED AMOUNT |
|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | | | |
| | ☐ | ☐ | ☐ | ☐ | | | |
| | ☐ | ☐ | ☐ | ☐ | | | |
| | ☐ | ☐ | ☐ | ☐ | | | |
| | ☐ | ☐ | ☐ | ☐ | | | |

PERCENTAGE OF TREATMENT NECESSARY AS A DIRECT RESULT OF THE QUALIFYING CRIME: LESS THAN & INCLUDING 50% ☐ MORE THAN 50% ☐ 100% ☐ — TOTAL CHARGES FOR THIS BILL

| AMOUNT PAID BY CLAIMANT | DOES CLAIMANT HAVE INSURANCE? YES ☐ NO ☐ | NAME & TELEPHONE NO.OF INS. COMPANY (IF AVAILABLE, PLEASE PROVIDE COPIES OF EXPLANATION OF BENEFITS). | HOW WAS CLAIMANT REFERRED? ☐ County Mental Health Plan (Medi-Cal) ☐ Victim Witness ☐ Other (Please specify) |
|---|---|---|---|
| | | | |

| AMOUNT WRITTEN OFF | AMOUNT PAID BY OTHER | IF PAID BY OTHER, WHO MADE THE PAYMENT? |
|---|---|---|
| | | |

**PROVIDER DECLARATION**: I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form, and to the best of my information and belief, all my answers are true, correct, and complete, and; (2) all treatment noted on this bill (including attachments) was necessary as a direct result of the crime described on the patient's original Application for Crime Victim Compensation. I further understand that if I have provided any information that is false, intentionally incomplete, or misleading, I may be found liable under Government Code section 12651 for filing a false claim with the State of California and may also be guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).
If the claimant did not sign below, I certify that these services were provided to ( ) a minor or ( ) an adult victim and that every effort to locate the responsible adult has been made to no avail.

THERAPIST'S SIGNATURE _____ DATE _____ SUPERVISING THERAPIST'S SIGNATURE _____ DATE _____

**TO BE COMPLETED BY CLAIMANT**

| CLAIMANT NAME (First, middle initial, last) | SOCIAL SECURITY NO. | DATE OF BIRTH | PHONE NO. (Work/home) |
|---|---|---|---|
| | | | |

| MAILING ADDRESS (city, state, and zip code) | IS THIS A NEW ADDRESS? YES [ ] NO [ ] |
|---|---|
| | |

**CLAIMANT DECLARATION**: I declare under penalty of perjury that I received the services listed on the date(s) indicated, that all treatment sessions for this bill are direct result of the qualifying crime described on my original Crime Victim Compensation Application and that I have signed this bill only after the services were provided.

CLAIMANT'S SIGNATURE (Parent or Guardian's Signature if Patient is under age 18) _____ DATE _____